

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9385

State File No.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2868

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME True Crouch

3. (b) If veteran, name war No. No. 3. (c) Social Security No. 492-09-4170

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased July 29 1881  
(Month) (Day) (Year)

8. AGE: Years 58 Months 7 Days 26 If less than one day hr. min.

9. Birthplace Troy Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name Joseph Crouch 13. Birthplace Troy Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Malynda Croyse  
15. Birthplace Troy Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ella Crouch  
(b) Address 3291 Regal Pl.

17. (a) Removal (b) Date thereof 3-27-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAR 27 1940 (b) J. F. Bricker  
(Date received for filing) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 13  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3291 Regal Pl.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25  
year 1940 hour 1 minute 38 A. M.

21. I hereby certify that I attended the deceased from Feb 22  
1940 to March 25 1940  
that I last saw him alive on March 24 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Edema of Lungs.  
Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature D. A. Thompson (M. D. or other)

Address 3121 N. Grand Date signed 3/26

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*J. G. Sullivan*

Licensed Embalmer No. 1122

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**